WEST VIRGINIA Department of Health & Human Resources

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) APPLICATION

You have the right to file an application the same day you contact the County Office. **To file an application, you need only complete your name, address, and signature, and turn this form into the County Office where you live.** We will interview you to decide if you are eligible. You will receive benefits from the date we received your signed application if you are determined eligible.

Your Name (First, Middle, Last)		**Birth Date (Month, Day, Year)**	**Social Security Number**
Mailing Address		**Street Address, if Different**	
City	**State**	**Zip Code**	**Telephone/Message Number During the Day**

EXPEDITED SERVICES

You may receive SNAP benefits within 7 calendar days if: your SNAP household has less than $150 in monthly gross income and liquid resources such as cash, checking or savings accounts are less than or equal to $100; or your rent/mortgage and utilities are more than your household's combined monthly income and liquid resources; or a member of your household is a migrant or seasonal farm worker.

1. How much money do the members of your household have in cash or a bank account? $ _____
2. What is the **total** amount of income you expect your household to receive this month? $ _____
3. What is your **current** monthly rent/mortgage payment? $ _____ Utilities $ _____
4. Is anyone in your household a migrant or seasonal farm worker? ☐ Yes ☐ No

   If yes, answer these questions: Did all of your household income stop recently? ☐ Yes ☐ No

   Does anyone in your household expect to receive income from a new source this month? ☐ Yes How ☐ No

Have you or anyone in your household received or do you expect to receive SNAP benefits from any other state this month?

☐ Yes Where ☐ No

Your Signature	**Date**

AUTHORIZED REPRESENTATIVE

You may appoint someone outside your household to act for your household to make an application and to be interviewed. This person should know your household's situation well enough to give any information needed to determine your eligibility for SNAP. You are still responsible for the information that anyone acting as your authorized representative gives, including any information that may be incorrect. If you want to appoint someone for this, write his/her name here:

HOUSEHOLD MEMBERS

NAME Last, First, MI	*Social Security Number	Date of birth	Sex	Marital Status	Relation-ship to you	Buy/ cook food together	*Citizenship Y/N	Alien Registration Number	In school Y/N	Last grade attended

****OPTIONAL - If Hispanic/Latino, ethnicity (check all that apply)**

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

****OPTIONAL - Race (check all that apply)**

☐ White	☐ American Indian or Alaska Native	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan
	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
				☐ Other_____

*You may leave this blank for anyone not in the assistance request.

**Not required. This information is voluntary. Your benefits will not be affected if you do not answer the race and/or ethnicity questions above. Giving us this information will help ensure program benefits are distributed without regard to race, color, or national origin.

HOUSEHOLD'S DECLARATION INQUIRY

☐ Yes	☐ No	1	Have you or any member of your household been convicted of trading SNAP benefits for drugs after September 22, 1996?
☐ Yes	☐ No	2	Have you or any member of your household been convicted of buying or selling SNAP benefits over $500 after September 22, 1996?
☐ Yes	☐ No	3	Have you or any member of your household been convicted of a felony under Federal or State law for possession, use or distribution of a controlled substance (felony drug conviction) after August 22, 1996?
☐ Yes	☐ No	4	Have you or any member of your household been convicted of fraudulently receiving duplicate SNAP benefits in any State after September 22, 1996?
☐ Yes	☐ No	5	Are you or any member of your household hiding or running from the law to avoid prosecution, being taken into custody or going to jail for a felony crime or attempted felony crime, or violation of parole or probation?
☐ Yes	☐ No	6	Have you or any member of your household been convicted of trading SNAP benefits for guns, ammunitions, or explosive after September 22, 1996?

If you answered "YES" to any of the above questions, please explain here.

Verification of some information is required.

If you have an expense that you do not report and/or provide proof of, you will not receive the deduction for the expense.

RESOURCES/ASSETS

Does anyone in your household have any resources or assets such as a checking or savings account, stocks, bond, cash on hand, property other than where you live, prepaid burial plan, trust fund? □ Yes □ No If yes, list below.

NAME OF OWNER	TYPE OF RESOURCE/ASSET	BALANCE/VALUE	LOCATION (name of bank, at home, etc.)

EARNED INCOME

Does anyone in your household receive any income from employment? □ Yes □ No If yes, list all gross income **before deductions** (such as full or part-time employment, self-employment, baby-sitting, odd jobs, days work, roomer/boarder payments, etc.)

NAME	NAME OF EMPLOYER (include address and phone number)	START DATE	RATE OF PAY	NUMBER OF HOURS WORKED	AMOUNT PER PAY PERIOD	HOW OFTEN RECEIVED

OTHER INCOME AND BENEFITS

If anyone in your household receives, applied for or was denied any benefit listed below, place a check in the box next to the benefit.

☐ Alimony	☐ Child Support	☐ Unemployment Benefits	☐ Education Grants or Loans
☐ Railroad Retirement	☐ Veteran's Pension/Benefit	☐ Union Benefits	☐ Disability/Sick, or Maternity Benefits
☐ Worker's Compensation	☐ Pension or Retirement	☐ Black Lung Benefits	☐ Money from friends or relatives
☐ Military Allotment	☐ Money from Rental Income	☐ Temporary Cash Assistance	☐ Mineral Rights
☐ Lump Sum Cash Amounts	☐ Social Security	☐ SSI	
☐ Interest Dividends from Stocks, Bonds, Savings or Other Investments		☐ Other _____	

If you checked yes to receiving, applying for or being denied any benefits, fill in below.

HOUSEHOLD MEMBER	TYPE OF BENEFIT	APPLIED		CLAIM NUMBER	RECEIVED		AMOUNT
		Yes	No		Yes	No	
		Yes	No		Yes	No	
		Yes	No		Yes	No	
		Yes	No		Yes	No	
		Yes	No		Yes	No	

CHILD SUPPORT

Does any household member pay legally obligated child support to a **NON-HOUSEHOLD** member? ☐ Yes Who? ☐ No
(includes current payments, arrearages, health insurance)

PERSON WHO PAYS	TYPE OF PAYMENT	MONTHS PAID IN LAST 3 MONTHS	COURT ORDER AMOUNT	AMOUNT ACTUALLY PAID

MEDICAL EXPENSES

SNAP – Do you or any household members pay medical expenses for any person age 60 or over, or any person receiving disability benefits? ☐ Yes ☐ No If yes, check the appropriate box and list the monthly amount you pay.

☐ Health/Medicaid Insurance	$	☐ Medical/Dental Insurance	$	Others	
☐ Dentures/Glasses/Hearing Aids	$	☐ Transportation Costs	$		
☐ Hospital	$	☐ Nursing	$		
☐ Attendant Care	$	☐ Pharmacy Expense	$		

SHELTER AND UTILITY COSTS

Is anyone in your household paying for any of the following? Check all those paid and answer the questions.

√	EXPENSES	AMOUNT	HOW OFTEN?	WHO PAYS?	√	EXPENSES	AMOUNT	HOW OFTEN?	WHO PAYS?
	Rent					Water			
	Mortgage					Sewer			
	Electric					Garbage			
	Gas					Wood/Coal			
	Oil					Property Tax			
	Telephone					Homeowner's Insurance			
	Land Contract					Other			

Is heat included in your rent? ☐ Yes ☐ No

If heat is not included in the rent, what is your source of heat? _____ Do you pay for air conditioning? ☐ Yes ☐ No

IMPORTANT INFORMATION ABOUT SNAP

The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the basis of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov. Individuals who are deaf, hard of hearing, or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339 or (800) 845-6136 (Spanish).

IMPORTANT INFORMATION ABOUT SNAP (Continued)

For any other information dealing with Supplemental Nutrition Assistance program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish, or call the State Information/Hotline Number at (800) 642-8589.

USDA is an equal opportunity provider and employer.

Read each statement carefully and sign the last page.

1. I understand the SNAP benefits are to be used by or on behalf of my assistance group and me to purchase food or seeds. I cannot sell my SNAP benefits or use someone else's benefits for myself. SNAP benefits will not be used for any other purpose. I understand that I may not use my SNAP benefits to purchase food on credit. This means I cannot pay for food already purchased or food to be received in the future.

   I understand that I cannot do, or attempt to do the following either in public, in private, or online: buy, sell, trade, steal or otherwise use SNAP benefits for monetary gain or other considerations; purchase food in containers with deposits and discard the product to receive cash refund deposits; and purchase or sell food originally purchased with SNAP benefits for monetary gain or other considerations. *Any of these actions is considered SNAP trafficking.*

2. I understand if any member of my assistance group is found (by court action or an administrative disqualification hearing) to have committed an act of intentional program violation, including trafficking, the individual will not receive SNAP benefits as follows: First Offense – one year; Second Offense – two years; Third Offense – permanently. In addition, I understand my assistance group will have to repay any benefits received for which it was not eligible.

3. I understand if an individual:
   a. Is found guilty in a federal, state, or local court of trading SNAP benefits for firearms, ammunition, explosives, or controlled substances; is a convicted felon, for possession, use or distribution of a controlled substance(s); or is found guilty of trafficking $500 or more in SNAP benefits, the guilty party will be permanently disqualified from participating in the SNAP Program.
   b. Makes a false statement or misrepresentation of identity and/or residence or receive duplicate benefits at the same time, the responsible party will be disqualified from the SNAP program for 10 years.
   c. Is found guilty of using or receiving benefits in a transaction involving the sale of a controlled substance, the guilty party will not be eligible for benefits for two years for the first offense and permanently for the second offense.

4. I understand that my SNAP benefits will be deposited in an EBT account and cannot be replaced under any circumstances. If I choose an authorized cardholder who has access to my EBT account, benefits used by the authorized cardholder also cannot be replaced. I also understand that if I do not use SNAP benefits deposited in an EBT account for a period of 180 days, that the benefits will be unavailable to me unless I contact the DHHR office, and after proper notice the benefits may be used to repay outstanding claims. I also understand that if I do not use benefits in an EBT account for a period of 365 days that the benefits will be removed from the account. I may voluntarily request that the benefits in my account be used to repay claims established against my SNAP benefits at any time.

5. I understand that if I fail to report or verify any household expense(s) that may entitle my household to an income deduction, I will not receive that deduction. This means I may not receive the full amount of SNAP benefits for which my household may be eligible. I understand that once I report and verify the expense(s) as required, I have the right to receive any calculated deduction beginning the following month.

6. I understand that if I receive SNAP benefits I have to report when total household income exceeds the SNAP gross income limit. I also understand that I will be notified what this amount is and that I must report this to DHHR by the 10th of the month after the increase happens. I understand that none of the other SNAP reporting requirements listed on this form apply to my household.

7. I understand that unless I am exempt, I must comply with work requirements by registering with WorkForce West Virginia and providing information about employment status and job availability.

8. I understand that if I refuse or quit employment or reduce my work hours to below 30 hours per week without good cause I may be penalized.

9. I understand that I am authorized to receive information and referral services about TANF-funded programs as well as other programs offered by the WV Department of Health and Human Resources and other organizations in West Virginia. I understand that this information will be included in every SNAP notification letter sent to me.

10. I understand that any information given is subject to verification by an authorized representative of DHHR.

11. I understand that providing my Social Security Number (SSN) to DHHR is mandatory and is required by federal law. I further understand that an SSN is required only for those people who apply for and/or receive benefits and not for any other purpose.

12. I understand that all persons included in the benefit must provide a Social Security Number (SSN). The SSN will be used to check the identity of household members, prevent duplicate participation and to make mass changes. It will also be used in computer matching and program reviews or audits to make sure my household is eligible for the benefits received. I understand this information may be disclosed to other Federal and State agencies for official examination, and to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law. Any fraudulent acts discovered may result in criminal or civil action or administrative claims against any person found to have committed such acts.

13. I hereby consent to be referred to the Social Security Administration to be issued a Social Security Number (SSN) and to have my SSN released only for the purposes described above.

14. I understand that DHHR will obtain income and eligibility information from the SSA, Internal Revenue Service (IRS), BCSE, Department of Motor Vehicles, Veteran's Administration, Bureau for Public Health, Worker's Compensation, Bureau of Employment Programs, Division of Rehabilitation Services, Office of Inspector General, Bureau for Medical Services (BMS), Systematic Alien Verification and Eligibility (SAVE) System, and U.S. Citizenship and Immigration Services (USCIS) about each member of my group. This information will be obtained by the use of the SSN of each applicant/recipient.

15. I understand that appointments/meetings with my Worker may include scheduled and/or unscheduled home visits, but I also understand that I am not required to allow the DHHR Worker to enter my home. I further understand that I will be required to cooperate with the Quality Control Reviewer in any review of my benefits as a matter of eligibility. This may require a home visit by the Reviewer and include additional verification of my situation, but I also understand that I am not required to allow the Quality Control Reviewer to enter my home.

16. I understand that I may receive information and a referral to receive Family Planning Services upon request.

17. I understand that I may receive information and a referral for Domestic Violence services upon request.

18. I understand if I am not satisfied with any action taken on my case, or if I feel I have been treated unfairly because of my race, age, color, national origin, sex, disability, political belief, or religion, I may ask for a Fair Hearing orally or in writing. (Please see page 5 for the address for discrimination complaints.) I understand that anyone may attend the Fair Hearing but, if I choose to have a lawyer attend, the DHHR will not pay the lawyer's fee. I also may complete a civil rights complain form, IG-CR-1, at my local office.

19. I understand that I may be qualified to apply for low-price telephone services such as Tel-Assistance/Lifeline that the telephone company in my area offers. I give permission to the DHHR to release information to the telephone company concerning my eligibility for this service. If my eligibility for DHHR Programs is stopped, I understand the DHHR will notify my telephone company.

20. I give my permission specifically to the West Virginia State Tax and Revenue Department and the IRS to release to the DHHR any and all information from my personal and/or business income tax returns for any and all tax years that would have to do with my receiving benefits and which is required by federal regulations and/or DHHR policy. This includes filing status, dependents, address, income, deductions, and any other pertinent information requested by DHHR.

21. I give my permission to the DHHR to provide information contained in my confidential case record, regarding me or any member of my family or assistance group, to INS, SSA, BCSE, BMS, Bureau for Public Health, Division of Rehabilitation Services or any other State or Federal Agency, Department, or Organization primarily for the purpose of providing me with access to the services and benefits offered by these entities in an efficient manner that allows for coordination rather than duplication of service(s).

22. I understand that DHHR does not discriminate on the basis of disability in admission to or access to its programs or in its operations, services, or disability in admission to or access to its programs or in its operations, services, or activities. This notice is available in large print, on audio tape, or in Braille from any office. This notice is provided as required by Title II of the Americans with Disabilities Act (ADA) of 1990. If I have questions I may contact the Equal Employment Opportunity and Civil Rights Compliance Officer, DHHR Office of Human Resources Employee Management, One Davis Square, Suite 400, Charleston, WV 25301, by phone Monday through Friday, 9:00 am to 5:00 pm, at 304-558-0727 or by email at dhhremployeemgmt@wv.gov.

22. I give my permission for any financial institution, government agency or department, physician (including psychiatrists, psychologists or other counselors), drug testing facility, hospital (including psychiatric hospitals), business concern, HIV/AIDS testing service, or other person with related information to release any information to the DHHR when this information is related to my receipt of assistance. I understand that only information which is required by federal regulations and/or DHHR policy will be requested and that it will be used only in determining or redetermining my eligibility for assistance or the level of assistance received. This release authorizes schools to provide information including, but not limited to, enrollment, attendance, address, custodian, and all information related to the receipt of public assistance for my child(ren) under my care and custody.

23. I understand that my assistance group may be required to repay any benefits paid to or on behalf of it for which it was not eligible because of unintentional errors made by me or by DHHR. I also understand that if I give incorrect or false information or if I fail to report changes that I am required to report, my assistance group may be required to repay any benefits it receives, and I may also be prosecuted for fraud. Additionally, I understand that all adult members of my assistance group are equally and separately responsible for an overpayment of assistance. I also understand that any person who obtains or attempts to obtain benefits from DHHR by means of a willfully false statement or misrepresentation or by impersonation of any other fraudulent device can be charged with fraud. Punishment upon a conviction may be fine up to $10,000.00 and/or a jail sentence of 10 years in a state correctional facility. **For the SNAP Program Only**—federal penalties may include a maximum fine of $250,000.00 and a jail sentence of up to 20 years. **For the LIEAP Program Only**—failure to repay such benefits may result in loss of future LIEAP benefits.

I certify by signing my name below, under penalty of perjury, that I have correctly listed the citizenship or alien status of the individuals applying for benefits on this application. This declaration of United States Citizenship or alien in lawful immigration status is a condition of eligibility for WV WORKS, Health Coverage and SNAP. Any household member for whom citizenship is not declared is not eligible to receive benefits. However, their income and assets will be considered available to the remaining members of the household.

I understand that it is a criminal violation of federal and state law to provide false or misleading information for the purpose of receiving to which I am not entitled. I understand it is my responsibility to provide complete and truthful information.

Please sign and date the form below

X_____ _____

Signature of SNAP Household Member Date